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October 6, 2008

MEMORANDUM

TO:
Legislative Oversight Committee Members
Local CFAC Chairs
NC Council of Community Programs
County Managers
State Facility Directors
LME Board Chairs
Advocacy Organizations
MH/DD/SAS Stakeholder Organizations
Commission for MH/DD/SAS
State CFAC
NC Assoc. of County Commissioners
County Board Chairs
LME Directors
DHHS Division Directors
Provider Organizations
NC Assoc. of County DSS Directors

FROM: William W. Lawrence, Jr., MD

Leza Wainwright

SUBJECT: Implementation Update #49
Medicaid Reimbursement: Psychiatric Reduction
Reporting Change in Provider Status
Enhanced Services Rate Changes
IPRS Monitoring of CS 25%
NEA Letters for 25% QP Requirement
Money Follows the Person Program
CAP/MR-DD Update

Medicaid Reimbursement for the Psychiatric Reduction

The Division of Medical Assistance (DMA) hereby provides notification of its amendment to the Medicaid State Plan. The change will provide reimbursement to cover the allowable portion of the Medicare payment reduction for outpatient psychiatric crossover claims for dually-eligible recipients of Medicare and Medicaid, up to 95% of the Medicare rate. This change is subject to existing eligibility restrictions.

This amendment is effective April 1, 2008. The implementation will require system modifications. Please refer to future bulletin articles for an implementation date. Providers should continue to file claims utilizing the current guidelines.

Reporting a Change in Provider Status

Medicaid providers are responsible for notifying Medicaid when information related to their business or practice changes. Failure to report changes may result in the suspension of a provider's Medicaid provider number and a delay in the receipt of claims reimbursement.

The Division of Medical Assistance has recently added a page to their website that clarifies the process for reporting a change to Medicaid. How a change is reported to Medicaid depends on the type of change that is being reported. Some changes require a provider to include specific types of documentation while other changes require a provider to submit a new Provider Participation Agreement or a new Provider Enrollment Packet.

Providers are encouraged to visit DMA's website at http://www.ncdhhs.gov/dma/provider/changematrix.htm and to review the requirements for reporting a change to Medicaid.

Revised Effective Date for Enhanced Services Rate Changes

The effective date for the following rate decreases that were published in the September 2008 general Medicaid bulletin has been changed from October 1, 2008, to January 1, 2009.

Service Code	Service Description	Service Unit	Current Rate	New Rate
H0020	Opioid Treatment	per event	$ 19.17	$ 18.74
H0040	Assertive Community Treatment Team	per event	323.98	301.35
S9484	Professional Treatment Services in Facility Based Crisis	per hour	18.78	17.99

The effective date for the following rate increases remains October 1, 2008.

Service Code	Service Description	Service Unit	Current Rate	New Rate
H0015	Substance Abuse (SA) Intensive Outpatient Program	per diem	$131.93	$148.52
H2035	SA Comprehensive Outpatient Treatment Program	per hour	45.76	51.20
H0012 HB	SA Non-Medical Community Residential Treatment	per diem	145.50	175.91
H0013	SA Medically Monitored Community Res. Treatment	per diem	265.25	272.99
H0010	Non-Hospital Medical Detoxification	per diem	325.88	367.57
H0014	Ambulatory Detoxification	per 15 min	20.43	23.99
H2011	Mobile Crisis Management	per 15 min	31.79	34.37
T1023	Diagnostic Assessment MH/SA	per event	169.06	261.13
H0035	Partial Hospitalization	per diem	121.69	149.38
H2017	Psychosocial Rehabilitation	per 15 min	2.90	3.03
H2015 HT	Community Support Team (MS/SA)	per 15 min	16.52	17.26

Fee schedules are available on DMA's website at http://www.ncdhhs.gov/dma/fee/mhfee.htm. Providers must always bill their usual and customary charges.

The tiered rates for Community Support have not been approved by the Center for Medicare and Medicaid Services yet. The existing single Community Support rate remains in effect.

IPRS Monitoring of CS 25%

The Division of Mental Health, Developmental Disabilities and Substance Abuse Services expects all state services to be provided in compliance with existing service definitions. However, DMH/DD/SAS does not expect LMEs to monitor the Qualified Professional (QP) 25% requirement for Community Support for state funded services at this time based on the variables in processing and reporting of IPRS paid claims data.

Notification of Endorsement (NEA) Letters for 25% QP Requirement

LMEs should notify a Community Support provider that has not met the 25% QP requirement for the previous three month period as quickly as possible following the LME making that determination. The provider should be advised that they have fifteen (15) business days to file an appeal for reconsideration by the LME. **No NEA letters should be issued at this point**. If the provider fails to appeal by the fifteenth (15^{th}) business day, the LME shall issue the NEA letter withdrawing endorsement effective the first of the second month following the month in which the determination was made in accordance with instructions in Implementation Update # 45. If the provider appeals but the LME does not grant the appeal, the NEA letter withdrawing endorsement shall be processed at the time of the decision not to grant the appeal. If the provider appeals and the LME grants the providers appeal, no NEA letter shall be sent.

For all NEA letters which represent an involuntary withdrawal endorsement, please remember to complete the section on page 2 outlining the reason for withdrawal.

Money Follows the Person Rebalancing Demonstration Program

In May 2007, the Center for Medicare and Medicaid Services (CMS) awarded the North Carolina Department of Health and Human Services (DHHS) a grant through the Money Follows the Person (MFP) Rebalancing Demonstration Program established by the Deficit Reduction Act of 2005. The grant is administered by the Division of Medical Assistance. This grant will support the transition of individuals living in nursing homes to the community; as well as, supporting individuals with intellectual and/or developmental disabilities (ID/DD) living in state-operated and community ICF-MR facilities to return to the community. The total projected number of individuals to be assisted in transitioning to the community from these populations is 304. The projected number of individuals with ID/DD to transition to the community is 80; 40 from community ICF-MR facilities and 40 from state operated developmental centers. The proposed Home and Community Based Services (HCBS) waiver currently at CMS has reserved 80 slots to support individuals with ID/DD to transition to the community through MFP.

Staff members from the Community Policy Management Section and State Operated Services in DMH/DD/SAS are working in collaboration with DMA in the implementation of the project which was effective October 1, 2008. Updates regarding the project, including the role of the LMEs and providers, will be provided as implementation progresses.

Questions regarding the project should be directed to:

Linda M. Hicks
Project Director, Money Follows the Person
North Carolina Division of Medical Assistance
Policy Development and Special Projects
919-855-4274

CAP/MR-DD Update

Health and Safety Checklist

The LMEs are required to complete the Health and Safety Checklists annually on non-licensed Alternative Family Living homes. This requirement is a part of the LME monitoring process, and is a continuing requirement, although, it is no longer necessary to submit the completed checklist to DMA or DMH/DD/SAS. The LMEs should maintain the completed checklists in their files.

Training for the Waivers

Training for the new waivers has been scheduled as follows, however based on the number of individuals registered for these events additional events are being planned and will be announced on the DMH/DD/SAS website.

- October 2, 2008 - Raleigh - LME training
- October 8, 2008 - Cherry Hospital - training for providers, participants and families; 2 repeat sessions
- October 15, 2008 - CenterPoint LME - training for providers, participants and families; 2 repeat sessions
- Sessions at conferences:
    - The Providers Council - October 7, 2008
    - Eastern Region Developmental Disability Conference - October 7, 2008
    - FARO - October 27-29, 2008
    - Best Practice Conference - November 12-14, 2008

New Services Endorsement Process

The new services include Behavioral Consultant, Home Supports, Long Term Vocational Service, and Crisis Respite. The Behavioral Consultant service is being revised due to significant changes made as a result of public comment. The revised definition will be posted for public comment. Therefore, the checksheet and instructions for Behavioral Consultant will not be finalized until the revision of the service is complete; consequently endorsement cannot be conducted until that time.

Home Supports is written and designed to contain elements and requirements consistent with the Residential Supports service definition. Therefore, for existing providers of Residential Supports who intend to provide Home Supports, endorsement is not required. **Existing providers of Residential Supports, who intend to provide Home Supports, are required to sign the attached attestation letter indicating compliance to the Home Supports service definition requirements.**

Providers should immediately submit an application to the LME (per the Provider Endorsement Policy) to request endorsement of the new services they intend to provide (Crisis Respite, Long Term Vocational Supports). The

endorsement/enrollment process is the same as the current process, with statewide enrollment of the services provided with DMA, and a signed MOA with each LME indicating which services they will deliver within the LME catchment area.

LMEs should immediately begin completing the endorsement process for the new services. Every effort should be made to complete the endorsement process by November 1, 2008. All new providers intending to provide Home Supports must be endorsed and enrolled with the Division of Medical Assistance prior to delivering the new services.

Additional Staffing Requirements Process
Modifications were made on the following *existing* services that include additional staff qualifications and training/core competencies requirements: **Adult Day Health, Crisis Services, Day Supports, Home and Community Supports, Personal Care, Residential Supports, Respite, and Supported Employment.**

Providers who intend to continue to deliver the existing services are required to sign an Attestation Letter indicating;

- their understanding of the new staff training/core competency service definition requirements, and
- attesting to their compliance of the added requirements prior to delivering the services, and
- acknowledging that the LMEs will monitor compliance to the requirements within 60 days of implementation of the waivers.

Providers are required to submit the signed Attestation Letter to DMA, Provider Services, with their completed DMA Addendum Application, copying the LME. LMEs are required to complete a monitoring review of these providers, within 60 days of implementation of the waivers or provider delivery of the service, to ensure compliance to the new requirements. DMH/DD/SAS will verify the completion of the LME monitoring of providers and make available for review or submission to DMA as requested.

Transition/Implementation
The DMH/DD/SAS has been working with the LMEs to gather the cost summary data for each participant. Division staff reviewed the data (cost summaries), compared to DMH/DD/SAS data and is making decisions about waiver assignments (which waiver each participant will be assigned) based on the information collected. The DMH/DD/SAS is working with the LMEs and case managers to notify participants, families and the local Department of Social Services to communicate the waiver assignments. Participants will receive letters notifying them of the waiver in which they are assigned.

The case manager should immediately begin work with participants/families to complete needed Plan of Care (POC) revisions, (as needed to add Home Supports and other new services if needed), and send to ValueOptions for approval to ensure POC revisions are processed in a timely manner.

Transition Process for Continued Need Reviews Due in October, November, December 2008
In order to provide continuity of care for CAP MR/DD participants in the upcoming movement to two new waivers, the following process will be in effect for participants whose birth month is October, November or December 2008.

1) The case manager remains responsible for completion of the required meeting for the development of the Continued Need Review (CNR). If a participant does not have a need for a new service (Home Supports, Long Term Vocational Support or Crisis Respite), the case manager will submit the Plan of Care as well as the required documentation to ValueOptions, the utilization review vendor, per the customary process.
2) If at the CNR meeting, the participant and/or guardian indicate the need for one of the new services noted in the above paragraph, which are new to the two waivers; the case manager will complete the CNR, attach the required documentation **AND** prepare a revision with the new services indicated according to the service definition and rates.

The reason for submitting the request for a new service in advance is that it allows for authorization to occur as soon as the waiver is approved by CMS and therefore allows for services to be rendered and billed accordingly.

Unless noted otherwise, please email any questions related to this Implementation Update to ContactDMH@ncmail.net.

cc: Secretary Dempsey Benton
Dan Stewart
DMH/DD/SAS Executive Leadership Team
DMA Deputy and Assistant Directors
Christina Carter
Sharnese Ransome
Kaye Holder
Wayne Williams
Shawn Parker
Denise Harb
Tom Lawrence

Attachment

CAP-MR/DD Letter of Attestation

The CAP-MR/DD service definition titled Home Supports is written and designed to contain the elements and requirements of Residential Supports. Therefore, endorsement is not required for existing providers of Residential Supports. **In order to be eligible to provide Home Supports**, **existing providers of Residential Supports**, **are required to sign this attestation letter demonstrating compliance to the Home Supports service definition requirements.**

As a current CAP-MR/DD Medicaid enrolled provider of Residential Supports, and in order to be eligible to provide the new CAP-MR/DD waiver service titled Home Supports, I attest to the following**:**

I fully understand all the requirements of the Home Supports service definition, including, but not limited to, all elements of the definition, limitations, staff training and qualifications. Further I understand I am solely responsible for ensuring the service is provided as defined in the service definition and am attesting to my compliance to the Home Supports service definition requirements effective November 1, 2008. I understand failure to comply with all requirements shall result in withdrawal of provider endorsement and enrollment with DMA.

Name: _____

Provider Address: _____

Provider Medicaid Enrollment Number: _____

Provider Signature: _____

Date: _____

Modifications were made on the following *existing* services that include additional staff qualifications and training/core competencies requirements: **Adult Day Health, Crisis Services, Day Supports, Home and Community Supports, Personal Care, Residential Supports, Respite, and Supported Employment.** Providers who intend to continue to deliver the *existing* services are required to sign this Attestation Letter indicating:

As a current CAP-MR/DD Medicaid enrolled provider of CAP-MR/DD services sited above I attest to the following:

I fully understand all the requirements of the _____ (list the service definition) service definition, including, but not limited to, all elements of the definition, limitations, **additional staff training and qualifications**. Further, I understand I am solely responsible for ensuring the service is provided as defined in the service definition and am attesting to my compliance to the added staff training/core competency requirements effective November 1, 2008. I understand failure to comply with all requirements shall result in withdrawal of provider endorsement and enrollment with DMA.

Name: _____

Provider Address: _____

Provider Medicaid Enrollment Number: _____

Provider Signature: _____

Date: _____